Covered Services Overview

SERVICE	IN-NETWORK *You Pay*	OUT-OF-NETWORK *You Pay*
Physician Services		
Office Visits	*$25 Copayment/visit*	40%
Home Visits	20%	40%
Inpatient Services and Supplies (including diagnostic X-rays and labs)	20%	40%
Outpatient Services and Supplies	20%	40%
Hospital Facility Services[1]		
Inpatient Services	20%	40%
Outpatient Services/Ambulatory Surgery	20%	40%
Family Planning Services		
Pre & Postnatal Exams	$25 Copayment for first visit only; all other office visits and maternity services included in Delivery/Newborn charges	40%
Delivery/Newborn Charges	20%	40%
Voluntary Termination of Pregnancy	20%	40%
Infertility Services (to correct a Medical Condition only; not to aid in conception)	20%	40%
Tubal Ligation (reversals not covered)	20%	40%
Vasectomy (reversals not covered)	20%	40%
Preventive Services		
Well Baby Care • Birth to 1: 7 visits • Age 1 to 4: 7 visits • *Age 5 to 11: 7 visits* • Age 12 to 19: 8 visits	$25 Copayment/visit	Not covered
Periodic Physical Exams	$25 Copayment/visit	Not covered
Specific Immunizations	$0	Not covered
Injections and Injected Substances	20%	40%
Allergy Testing and Treatment (Shots)	$25 Copayment/visit 20% – Allergy Shots and Testing	40% – Allergy Shots
Mammograms • One baseline between ages 35 and 39 • Every year from age 40	$0	40% *(routine not covered)*
Prostate Screening • Every plan year from age 40	$0	40% (routine not covered)
Outpatient Services		
Diagnostic Lab	$0	40% (routine not *covered)*
X-rays (X-rays not covered if performed in a Chiropractor's office)	20%	40% (routine not covered)

Filing a Prescription Drug Claim

Medco Health pays claims according to its established standards for prescription drug benefits. If the pharmacy does not file a claim(s) for you and/or your Dependent(s) or you go to an out-of-network pharmacy and must file your own claim:

1. Call Member Services at (800) 988-4105 to request a claim form or obtain one from www.medcohealth.com.
2. Read the instructions and complete a form for each claim. For assistance, ask the pharmacist or attach the receipts to your claim if they have all the required information, including the National Drug Code number for the prescription.
3. Make copies of all bills and claim forms. It is important to keep records for each Covered Family Member.
4. Attach all original, itemized bills to the corresponding claim form.
5. Mail the original claim form and itemized bills to:

   Medco Health Solutions, Inc.
   P.O. Box 14711
   Lexington, KY 40512

Filing a Prescription Drug Appeal

You have the right to appeal any denied claim. Your claim must be in writing and should include:

- The covered Associate's name, address and telephone number
- All member information from the covered Associate's ID card as it appears
- The name of the person for whom the claim applies and the date of service
- The name and contact information for the provider and place of service
- Description of the service and the charge for the service
- Statement of opinion as to why the denial was improper

You must submit your appeal within 180 days from receipt of the denial or you waive your right to request a review of the denied claim.

Unless otherwise stated in your notice of denial, submit appeals to the appropriate address below.

Submit first level appeals to:
Medco Health Solutions Attn: Coverage Reviews 8111 Royal Ridge Parkway Irving, TX 75063

Submit second level appeals to:
MCMC LLC c/o Medco Health Solutions 8111 Royal Ridge Parkway Irving, TX 75063

If a claim filed with the Medco by Mail program is denied, the notice of denial will include details about the appropriate process for filing an appeal and where to send your appeal. Refer to the "Claims" section at the beginning of this booklet for additional information about denied claims and what to expect from the Plan.

- A copy of the EOB (if available)

Submit written medical/behavioral health appeals and/or grievances to:

Empire BlueCross BlueShield
P.O. Box 5065
Middletown, NY 10940-9065
For additional information call: (800) 675-1277

You must submit your appeal or grievance within 180 days from receipt of the denial or you waive your right to request a review of the denied claim.

Refer to the "Claims" section at the beginning of this booklet for additional information about denied claims and what to expect from the Plan.

Medicare Part D Eligibility

If you are eligible for Medicare, you should receive a notice from the Associate Service Center indicating that the prescription drug coverage offered under the medical plan is creditable (i.e., on average, as good as Medicare Part D) and what your Part D enrollment options are. It is very important that you read that notice because you may be subject to a late enrollment penalty if you do not timely enroll in Medicare Part D. If you did not receive a copy of that notice or you would like another copy, contact the Associate Service Center.

You can find more information on Medicare Prescription Drug Plans (including Medicare enrollment periods) at www.medicare.gov or by calling (800) MEDICARE (1-800-633-4227). TTY users should call (877) 486-2048.

Health Care Self-Audit Bonus

The Health Care Self-Audit Bonus rewards Participants for their efforts in helping to control excess billing costs. Hospital, doctor and other provider bills can have charges listed in error, such as X-rays that were not given, medical supplies not used, blood not received, or procedures that were not performed. For example, Participants might be charged for more days than they actually stayed in the Hospital or at the private rather than the semi-private room rate.

Review (audit) all medical bills and EOBs to make sure they are correct. Ask for an itemized bill from your doctor and/or Hospital upon being discharged. If you find an error in the bill after the claim is paid or if the claim is processed incorrectly, Circuit City will pay you 50% of the first $200 saved and 25% over $200. The maximum self-audit bonus is $1,000. Example: If you find an error that the Plan paid $300 more than it should have, Circuit City will pay you a bonus of $125 (50% of $200 plus 25% of $100).

If you find an error on a medical bill:

1. Contact the Physician's office or Hospital to determine the correct charge;
2. Confirm the adjustment of charges; and then,
3. Send your request for a self-audit bonus along with the original bill, the revised bill and the EOB to:

   Circuit City Stores, Inc.
   Attn: Benefits Department
   9954 Mayland Drive
   Richmond, VA 23233-1463

Self-audit bonus requests must be submitted within 12 months from the date services were received.

Filing a Medical or Behavioral Health Claim

If your Health Care Provider does not file your claim for you, you may obtain the most current version of the claim form by calling Empire Customer Service at (800) 675-1277. Follow these steps to file a claim for medical or behavioral health services:

- Complete and sign the claim form(s). The provider will need to complete the front portion of the form. File separate claims for each covered Participant.
- Make copies of all bills and claim forms for your records and attach all original, itemized bills to the corresponding claim form.
- Mail the original claim form and itemized bills to:
  Empire BlueCross BlueShield
  Dedicated Service Center
  P.O. Box 5065
  Middletown, NY 10940-9065

Payment of Medical and Behavioral Health Claims

After Empire receives complete claim information, payment will be made to the appropriate payee:

- Directly to the provider when the provider assumes responsibility for the claim (generally when the provider is in-network); or
- Directly to the Participant for reimbursements of qualified payments made by the Participant.

Benefits for covered Dependents after the covered Associate's death will be paid to one of the following:

- The surviving spouse;
- The Dependent child who is not a minor, if there is no surviving spouse;
- A Hospital or a person who submits charges on behalf of Dependents, for services covered under this Plan; or
- The legal guardian of the Dependent.

Payment of Claims for Pre-existing Conditions

If Empire receives claims for conditions that could be pre-existing, the carrier will request a Certificate of Creditable Coverage from you to determine any exclusion. If it is determined that the claim involves a Pre-existing Condition, you will be notified accordingly. If the limitation does not apply, the claim will be processed according to Plan design.

Explanation of Benefits (EOB)

For each claim processed, an Explanation of Benefits (EOB) is mailed to the Participant. EOBs may be available on-line as well. The EOB shows the amount of the charge, the amount covered, the amount applied to the Deductible, Coinsurance, and network adjustment, if applicable, and the amount to be paid. Keep EOBs for your records.

Filing a Medical or Behavioral Health Appeal or Grievance

You have the right to appeal or file a grievance for any denied claim. You may authorize, in writing, a representative to act on your behalf in filing your appeal or grievance. Your appeal/grievance must be in writing and should include:

- The covered Associate's name, address and telephone number
- All member information from the covered Associate's ID card as it appears
- The name of the person for whom the claim applies and the date of service
- The name and contact information for the provider and place of service
- Description of the service and the charge for the service
- Statement of opinion as to why the denial was improper

Health Management

Based on your prescription and health information, Medco Health may invite you to participate in one or more of their health management programs. Program Participants generally receive educational mailings and toll-free phone access to registered pharmacists. In some programs, Participants may also receive follow-up calls from Medco Health pharmacists. These voluntary programs support your doctor's care and Medco Health may contact your doctor regarding your eligibility for, or participation in, these programs.

Drug Utilization Review

When you or your Dependents fill prescriptions through the Medco by Mail program or a retail pharmacy, pharmacists use the health and prescription information on file to consider many important clinical factors, including drug selection, dosing, interactions, duration of therapy and allergies. At times, Medco Health may contact your doctor to discuss your prescription(s). If your doctor authorizes any changes to your prescription, such as substitution with generic drugs, Medco Health will send a confirmation letter to you and your doctor.

Only the medication authorized by your doctor will be dispensed to you.

Education and Safety

To keep you informed about issues specific to your health, prescriptions may include information about critical topics like interactions and possible side effects. Medco Health's website, www.medcohealth.com, offers additional information about health related topics. Remember to follow your Health Care Provider's advice and treatment plan. Consult your Health Care Provider before making changes to your lifestyle and/or treatment.

Claims

In-network Providers for BlueCross BlueShield, Anthem Behavioral Health and Medco Health Solutions have agreed to submit Participants' claims directly. Non-network Providers may file claims for you if you present your ID card at the time of service. However, if the Non-network Provider doesn't file the claim for you, you must submit a Non-network claim form to Empire BlueCross BlueShield. Claim forms can be found on the website at www.empireblue.com/circuitcity.

Claims must be submitted in a timely manner according to the deadlines listed below.

Type of Claim	Submission Deadline
Initial Claims	Within 12 months from the end of the Plan Year in which service was received
Concurrent Claims	At least 24 hours prior to the end of the prior-authorized service(s)
First Level Appeals/Grievances*	Within 180 days from the date of the decision on your initial claim
Second Level Appeals/Grievances*	Within 60 days from the date of the first level appeal/grievance decision

*An appeal is a request for review of a denied claim for benefits. A grievance is a request to have the Plan reconsider a denied claim, based on benefits other than those addressed in the initial claim. Appeals and grievances submitted after the deadline for submission will not be reviewed again and the preceding decision will stand.

When you use Medco by Mail, you and your Dependents can save money by filling up to a 90-day prescription drug supply for about the same cost as a 75-day supply.

How to Fill Your Medco by Mail Prescription:

Via Fax

1. Give your doctor your member number from your Prescription ID card and have your doctor call (888) EASYRX1 [(888) 327-9791]
2. The Medco by Mail program faxes your doctor a prescription fax form to complete and return via fax
3. You will receive a bill in the mail with each prescription

Via Mail

1. Ask your doctor to write two prescriptions:
   - One prescription for a 30-day supply with no refills that you can take to be filled immediately at a participating retail pharmacy
   - Another prescription for a 90-day supply with three refills that you fill through the Medco by Mail program
2. Mail the written prescription with the mail-order form from your Medco Health Welcome Kit. You may pay by credit card when you send in your prescription, or you may elect to be billed upon receipt of your prescription.

To obtain a Medco by Mail form, call Medco Health at (800) 988-4105 to request a paper copy or go to www.medcohealth.com and print the PDF version. Use the group name 'CIRCUIT' when you complete the form.

How to Request Prescription Refills

You may request refills via the Internet, telephone or mail:

- On-line, go to www.medcohealth.com
- By phone, call (800) 4REFILL [(800) 473-3455]
- By mail, complete the refill form and mail it with your Coinsurance payment to:
  Medco Health Solutions, Inc.
  Medco by Mail Program
  P.O. Box 747050
  Cincinnati, OH 45274-7050

Additional Prescription Drug Services

The Prescription Drug Program is designed to provide high quality care and service that you expect whether it's keeping a record of your medication history, providing toll-free access to a registered pharmacist or keeping you up to date on any changes in the program. In addition to easy access and flexibility, the program offers many features to help you manage your prescription drug costs and keep you informed about prescription drugs.

Prior Authorization

To prevent misuse and use of expensive and potentially dangerous drugs, proof of medical necessity may be required before a prescription for certain drugs will be paid by the Plan. Medco will contact you if your prescription requires prior authorization. Prior authorization may delay the prescription being filled.

The three tiers on the formulary include:

Generic Drugs
Medications for which the patent has expired, allowing other manufacturers to produce and distribute the medication under its chemical name. By law a generic drug must have the same active ingredients as its brand-name counterpart and is subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity. Generic drugs usually cost less than brand-name drugs, and are often substituted for this reason.

As part of your prescription drug program, the pharmacist may discuss with your Health Care Provider, whether a generic drug might be appropriate for you. Your Health Care Provider always makes the final decision on your medication and you may request to keep the original prescription. If you choose to keep the original brand-name prescription your Health Care Provider prescribed when a generic is available, you will be responsible for the generic drug Copayment, as well as the difference in cost between the brand-name drug and generic drug.

Formulary Brand Drugs
Medications that have been reviewed and approved for preferred status based on their proven clinical and cost effectiveness by a carefully selected group of physicians and pharmacists.

Non-Formulary Brand Drugs
Medications that have been reviewed by the same team of physicians and pharmacists who have determined that alternative drugs that are clinically equivalent and more cost effective are available.

Pharmacy Network

Because the pharmacy network is so large, no directory is published. Materials that you receive from Medco Health will list pharmacy chains that are represented in the network. Medco Health participating pharmacies are also listed at www.medcohealth.com. Your pharmacist will know if that pharmacy is a Network or Non-network Provider. If the pharmacy is Non-network, you may either purchase the prescription and receive reimbursement at the out-of-network benefit level, or find a network pharmacy to fill the prescription according to in-network benefits. If your pharmacy is out-of-network and would like to join, call Medco Health Member Services at (800) 988-4105.

Always present your ID card to the pharmacist when purchasing prescription drugs.

Exclusions

Certain drugs such as infusion drugs, ostomy supplies, durable medical equipment and other very specialized medications are not covered under the Prescription Drug Program, but may be covered under the Medical Plan. Refer to the "Covered Services" section or call Empire or Medco Health for specific coverage information.

The following exclusions apply to the Prescription Drug Program:

- Vitamins, except prenatal vitamins
- Contraceptive jellies, creams, foams and devices
- Drugs for cosmetic use or weight loss
- Drugs for work-related injuries
- Drugs administered in Hospitals, clinics or doctors' offices
- Drugs not approved by the FDA
- Drugs which are lost or stolen
- Drugs to facilitate a pregnancy but do not treat the cause of infertility

Medco By Mail

The Medco by Mail program offers you a convenient and cost-effective means of purchasing prescription drugs.

When Participants follow all of these steps, they will receive a higher level of benefits. If Participants do not receive authorization prior to a Hospital, psychiatric or substance abuse Treatment Center admission (by the next business day after emergency treatment), a special Deductible of $500 will apply to the covered charges.

If Participants do not call prior to receiving outpatient treatment or do not follow the authorized treatment plan, benefits will be reimbursed at the out-of-network benefit level.

Remember to obtain authorization from Anthem before services are received.

Prescription Drug Program

Medco Health Solutions
(800) 988-4105
www.medcohealth.com

Medical Plan Participants are automatically enrolled in the Prescription Drug Program, administered by Medco Health Solutions, Inc. The Program provides access to an extensive network of pharmacies across the country from which you can purchase Medically Necessary prescription drugs at discounted prices.

Plan Provisions and Coinsurance

PLAN PROVISION	RETAIL (30-DAY SUPPLY)	MEDCO BY MAIL (90-DAY SUPPLY)
Generic	$10	$25
Formulary Brand	20% ($25 min; $60 max)	20% ($63 min; $150 max)
Non-formulary Brand	40% ($40 min; $75 max)	40% ($100 min; $188 max)

The price for prescriptions filled through Medco Health network pharmacies and Medco by Mail is based on average wholesale prices. Since these prices could be recalculated every day, you could pay a slightly different amount each time you fill a prescription because of cost fluctuations.

Certain quantity limits may apply and you may need to try one medication before benefits for the use of another medication can be authorized. Medco and your pharmacist will let you know if these limits apply.

If you request a formulary brand-name drug when a generic drug is available, you are responsible for the generic Copayment plus the difference in the cost.

Formulary

A formulary is a list of commonly prescribed drugs covered by the Plan. The formulary includes three tiers of drugs: generics, formulary brand and non-formulary brand. To download a copy of the formulary, go to www.medco.com and choose "physician" from the left-hand menu, then select "formulary." The formulary may change so be sure to download a new copy of the formulary throughout the year.

Behavioral Health

Anthem Behavioral Health
(800) 675-1277
Select the appropriate prompt for your inquiry
www.empireblue.com/circuitcity

As a Participant in the Medical Plan, you and your covered Dependents may participate in the Behavioral Health Program administered by Anthem. You can contact Anthem by calling the Empire Service Center at (800) 675–1277.

When you call Empire and get the voice prompt, enter your ID information and follow the steps below:

- Press 3 for Pre-certification and Mental Health
- Then press 1 for Mental Health
- Finally, press 1 again to transfer to Anthem

The Program offers:

- Confidential, toll-free access 24 hours a day, 7 days a week at (800) 675-1277 or www.empireblue.com/circuitcity
- Easy access to customer service representatives who will answer Participants' calls and refer them to a licensed, certified Mental Health or Substance Abuse Provider
- Clinical Case Managers who will work with Participants' providers to manage their treatment
- A full range of behavioral health services
- Help in finding inpatient or outpatient treatment for mental health and substance abuse from a network of providers practicing in a wide range of specialties

COVERED SERVICES	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Inpatient		
• Up to 30 days per Plan Year with a 60-day lifetime maximum for substance abuse, in- and out-of-network combined	80% after medical Plan Year Deductible	60% after $500 special Deductible and out-of-network Plan Year Deductible
Outpatient		
• Up to a total of 30 visits per Plan Year, in- and out-of-network combined	80% after medical Plan Year Deductible	60% after out-of-network Plan Year Deductible
Mental health and substance abuse Covered Expenses are included with the Medical Plan Covered Expenses to meet the Plan Year Deductible and Coinsurance Out-of-Pocket Maximum, except where noted above.		

When you call Anthem for assistance with behavioral health services, a customer service representative will gather information from you to help find the appropriate provider for your needs. In an emergency, a clinical case manager will provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility.

For behavioral health assistance:

- Call Anthem at (800) 675-1277 and choose the appropriate prompt or go to www.empireblue.com/circuitcity before outpatient treatment or admission to a Hospital, psychiatric or substance abuse Treatment Center (or within one working day after emergency treatment or admission)
- You will receive immediate phone counseling or a contact number to call a licensed, certified professional
- Call the provider recommended by Anthem to set-up your appointment(s)

Special Circumstances

Travel

If you or your covered Dependents require medical treatment while you are traveling, follow these guidelines:

- Within the United States, call the number on the back of your Medical ID card to find a provider near you.
- Outside the United States, call (804) 673-1177 to verify a participating facility. You may need to pay for services when they are provided. If this is the case, submit your claims to the Plan as soon as possible for processing and applicable reimbursement. Keep in mind that not all health care services are Covered Services.
- No matter where you are, prescription drugs must be FDA approved and covered under the Plan to be reimbursed. If you use a pharmacy that does not file your claim for you, submit the claim as soon as possible to receive reimbursement according to the Prescription Drug Program.

To avoid running out of any maintenance medication, request a prescription from your Health Care Provider and use the Medco by Mail program to fill a 90-day supply before you travel.

Emergency Medical Care

If emergency medical care is required, you or your Dependents may not have a choice about the facility to use. For this reason, the Plan will pay the Reasonable & Customary emergency charges according to the in-network Plan design.

In a life-threatening emergency, seek treatment immediately!

Emergency medical care is defined as medical services provided after the sudden onset of a Medical Condition manifesting itself by acute symptoms, including severe pain, where the symptoms are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy
- Bodily functions would be seriously impaired
- There would be serious dysfunction of a bodily organ or part
- Death

Emergencies include:

- Broken bones
- Knife or gunshot wound
- Heart attack
- Acute asthma attack
- Head injury
- Severe burn
- Stroke

If an emergency admission occurs, the Participant, or someone on her/his behalf, must call Medical Management as soon as possible. When the call is made, Medical Management will begin the review of medical necessity and appropriateness of care. If treatment is sought in an emergency room and is later determined not to be an emergency, no benefits will be paid.

There is a $150 Copayment for emergency treatment performed in an emergency room.

- To monitor appropriate patient care; and
- To coordinate communications among Health Care Providers and patients while providing emotional support to a patient's family.

These objectives will be met using Covered Services except in circumstances where Case Management recommends and authorizes alternative benefits.

Healthcare Advisor

The Healthcare Advisor service helps you compare hospital facilities, estimate the costs of specific healthcare services and procedures, and more. To access the Healthcare Advisor go to www.empireblue.com/circuitcity.

BlueCard Program

Empire participates in the BlueCard Program which gives you access to care when you are outside of Empire's service area. By presenting your ID card to any participating Hospital, Physician or other provider outside of Empire's service area anywhere in the United States, you will receive the Covered Services outlined in this Plan along with discounts that participating providers have agreed to with their local BlueCross BlueShield Plan.

When you obtain health care services through the BlueCard Program outside of Empire's service area, expenses that you are responsible for are based on the lower of:

- The amount the participating provider actually charges for the Covered Services provided to you, or
- The negotiated price that the out-of-area BlueCross BlueShield Plan passes on to Empire.

Exceptions:

A few BlueCross BlueShield Plans are governed by state laws that do not allow the Plan to calculate your expenses based on the lesser of the actual provider charge or the negotiated price. If you receive covered health care services in any of these states, your expenses for Covered Services will be calculated using the applicable state's statutory methods.

Some out-of-area BlueCross BlueShield Plans obtain a discount from the provider's billed charges and pass on the discount to Empire and ultimately to you. BlueCross BlueShield Plans outside the Empire service area may charge an access fee for making their negotiated rates and the resulting savings available on claims processed through the BlueCard Program. The fee is not included in the negotiated price, but rather is paid by Empire when the claim is finalized.

In some cases, Plans are able to determine only an estimated price for a Covered Service at the time a claim is paid. In other cases, a Plan's participating provider contracts apply average discounts to BlueCard Program claims. Plans using these methods may periodically adjust their future estimated or average prices to ensure appropriate pricing.

Centers of Excellence Program

The Centers of Excellence Program offers services to eligible Participants for organ and tissue transplant. When Centers of Excellence are used, Participants receive the maximum benefit for Covered Services. For details about Covered Services and benefits for Organ/Tissue Transplant, refer to Organ/Tissue Transplant in the Covered Services section of this Summary Plan Description.

Medical Management

Empire Medical Management
(800) 675-1277
9:00 a.m. to 5:00 p.m. EST
Monday through Friday

The Medical Management Program helps Participants and their attending Physicians determine the most appropriate care needed. The final decision about treatment rests with patients and their Physicians. Benefit payments are made according to Plan provisions.

When appropriate, Medical Management staff members discuss the planned level of care with the Participant and the attending doctor and advise the authorized level of benefit. To receive the maximum benefits available, the Participant or someone on her/his behalf should contact Medical Management in the following instances:

- As soon as possible, but prior to any scheduled inpatient or residential admission for medical, mental health or substance abuse treatment; as well as maternity if Hospital stay exceeds 48 hours for normal delivery or 96 hours for cesarean section;
- Prior to receiving alternative health care services including home health care, Private Duty Nursing after home health care, Hospice or Skilled Nursing Facility care (two weeks prior is recommended to ensure that Medical Management's review will be complete by the scheduled admission date);
- Prior to outpatient mental health or substance abuse treatment;
- By the next business day after an unscheduled or emergency Hospital admission; and
- Prior to receiving additional chiropractic, physical, speech and/or occupational therapy service beyond 10 visits per Plan Year.

If Medical Management is not contacted for admissions or alternative health care services, a special Deductible of $500 applies per occurrence. If Medical Management is not contacted prior to outpatient mental health or substance abuse treatment, benefits will be paid at the out-of-network benefit level.

If an unplanned admission occurs after hours or on a weekend or holiday, call Medical Management on the first business day following the admission.

Information to Provide to Medical Management:

- The Group Plan Number (on ID card)
- The covered Associate's ID number
- Name of the covered person receiving treatment
- Medical information concerning the treatment/confinement
- Physician's name, phone number and address
- Name of Hospital or other treatment facility

Case Management

Case Management is a service within Medical Management. It is designed to help in situations where you or a covered Dependent has a serious Illness or Injury requiring prolonged treatment. The primary objectives of Case Management are:

- To identify and coordinate cost-effective care alternatives which meet quality medical standards;

- Podiatry, including services for callus, corn paring or excision, toenail trimming and treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches, flat or pronated foot, pain or cramping of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot
- Pregnancy/Reproduction, including:
  - Charges for procedures and prescription drugs which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer
  - Charges for procedures and prescription drugs which increase sperm and egg production
  - Services for reversal of voluntary surgical sterilization or tubal ligation
- Regulations, including services available under federal, state or local laws and regulations, including Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act
- Transsexual surgery, includes intersex surgery (transsexual operations) or any resulting medical complications and/or sexual dysfunctions
- Vision, including:
  - Radial keratotomy, LASIK or other surgical procedures to correct refraction errors of the eye, including any confinement, treatment, services or supplies given in connection with or related to the surgery
  - Eye glasses, contact lenses, and routine eye (refractive) exams, except as specifically provided
- Work-Related, including:
  - Covered Services for which payment is made or available through Workers' Compensation or similar law
  - Injury which happens during work at any job for pay or profit
  - Drugs for work-related injuries

360° Health®

360° Health is a comprehensive series of preventive care programs, wellness information, case management and care coordination services, all seamlessly integrated to help achieve optimal health outcomes for participants. Programs included in 360° Health are 24/7 Nurseline, Maternity Care Program, Medical Management, Case Management, Healthcare Advisor, and much more.

24/7 NurseLine Program

The 24/7 NurseLine is an information hotline available to help you assess symptoms or explain a medical condition, diagnosis, procedure or prescription. You can call the 24/7 NurseLine toll-free at 1-877-TALK-2-RN (1-877-825-5276).

Maternity Care Program

Maternity Care is a comprehensive maternity program which promotes prenatal care and identifies members with high-risk pregnancies. Specially trained obstetric nurses work in conjunction with the expectant mother and her Physician to provide appropriate prenatal care. Participants may receive educational materials about pregnancy and related issues.

Case Management representatives and Maternity Care Program nurses are available by calling Medical Management at (800) 675-1277.

will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven for the treatment of that particular condition.

- Hearing appliances used to facilitate hearing but do not treat the cause of the hearing loss or impairment, such as hearing aids
- Inpatient services, including:
  - Inpatient care and services solely for observation or diagnostic testing
  - Inpatient services which could be rendered in a home, Physician's office or outpatient facility
- Medically Necessary, clinically inappropriate, experimental/investigational services or supplies determined not to be Medically Necessary or consistent with the diagnosis, including any confinement, treatment, service or supply given in connection with a service or supply which is not Medically Necessary. Includes X-ray examinations not incident to or consistent with the diagnosis of the Participant's condition.
- Medications:
  - Prescription refills in excess of the number specified by the Physician, limits for days' supply or any refill dispensed after one year from Physician's original prescription
  - Drugs not approved by the FDA
  - Drugs which are lost or stolen
  - Herbal medicine
  - Nonlegend drugs, except as specified, and excluded legend drugs such as: topical minoxidil, fluoride supplements, cosmetic drugs, smoking deterrents, any covered drug provided by a Hospital to a covered individual confined therein; any kind of device or apparatus, regardless of therapeutic effect (e.g., hypodermic needles and syringes, except for insulin or other injectables, support garments, similar items)
  - Holistic or homeopathic care, including drugs and environmental or ecological medicine
- Miscellaneous:
  - Charges for completion of claim forms or administrative fees
  - Charges for missed appointments
  - Custodial care
  - Injury or sickness caused by participation in declared or undeclared war, riot, civil disobedience or international armed conflict
  - Services of a person who is a member of the Participant's immediate family or who resides in her/his home, such as a spouse, sibling, parent or child
  - Services given by volunteers or persons who do not normally charge for their services
  - Services given by a licensed pastoral counselor to a member of her/his congregation in the course of her/his normal duties as a pastor or minister
  - Whole blood for which no payment is required
  - Any Covered Service for which payment to the provider is not required
  - Expenses not legally required to be paid
  - Amounts in excess of the Reasonable Charge for a Covered Service
  - Amounts above the 150 percent of Medicare reimbursement for out-of-network physician services
  - Care by interns, residents or practitioners who are employees of Hospitals, laboratories or other institutions
  - Services rendered in conjunction with those of an attending Physician whose services are not covered
  - Services, exams or tests not needed to treat accidental Injury, sickness or pregnancy, except as specifically provided by name in the Plan
  - Services or supplies not specifically listed as Covered Services
  - Telephone consultations
- Travel, except as provided under the Organ Transplant Program whether or not recommended by a Physician

- Therapy services, including physical, occupational and speech therapy. Therapy is the application of clinical skills and/or services that attempt to improve function to treat a disease or pathological condition. There is a limit of ten services per therapy category. Prior authorization is required for additional visits.
- Transportation and emergency medical care, including professional ambulance to and from a Hospital
- Transportation, required medical services, including professional ambulance to and from a medical facility
- X-ray and laboratory tests performed for diagnosis or treatment

Exclusions

The following exclusions apply to the Medical Plan, including the Prescription Drug Program and the Behavioral Health Program. In addition to any exclusions or limitations described in this SPD, the Plan DOES NOT cover services for:

- Anesthetics and charges for giving them when administered outside of an inpatient or outpatient facility, such as a doctor's office or dentist's office
- Chiropractic services, including:
  - X-ray examinations performed by a Chiropractor or in a Chiropractor's office
  - Physical therapy performed by a Chiropractor (unless licensed) or in a Chiropractor's office
  - Charges for office visits
- Cosmetic Care, including:
  - Services or drugs solely for cosmetic purposes
  - Surgery or treatment designed to improve the appearance of an individual by surgical alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasant or unsightly and which is not for the improvement of physiological function
  - Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness
  - Drugs for cosmetic use or weight loss
- Health club memberships for health clubs, figure salons, weight reduction clubs, programs or classes
- Personal hygiene and convenience items including, but not limited to, TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs
- Vitamins (except prenatal prescriptions) or minerals (except for severe deficiency), liquid protein or nutritional supplements
- Court orders, including:
  - Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment otherwise qualify as Covered Services
- Dental, including:
  - Appliances and adjustments to appliances for treatment of Temporomandibular Joint Disorder (TMJ)
  - Services of a Dentist or Physician for care and treatment of the teeth and gums except the services described under Covered Services
- Educational services, including
  - Services associated with autistic disease of childhood or learning disabilities and mental retardation
  - Sensitivity training, educational training therapy or treatment for an education requirement
  - Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
- Experimental Services, including health services and associated expenses incurred for services and supplies for Experimental, Investigational or Unproven services, treatments, devices, and pharmacological regimens. The fact that an Experimental, Investigational or Unproven Service is the only available treatment for a particular condition

- Benefits are payable for charges for Covered Family Members in connection with the following procedures:
  - Bone marrow/stem cell transplants
  - Heart transplants
  - Heart/Lung transplants
  - Kidney transplants
  - Kidney/Pancreas transplants
  - Liver transplants
  - Multiple major organ transplants
- Medical care and treatment for organ/tissue transplants include the following:
  - An evaluation for one of the procedures listed above
  - Pre-transplant or pre-medical/surgical care given after the evaluation including diagnostic tests and X-rays
  - Organ procurement/tissue harvest and preparation from a living donor
  - Surgery and recovery
  - Post discharge follow-up, including services and supplies, for up to one year after the transplant or medical/surgical procedure
  - Organ/Tissue Transplant Donor Charges
  - Donor testing is covered at 100% when using the Centers of Excellence and/or BlueCross BlueShield twork P ders
  - A $ time maximum applies for donor search. Non-network Providers are not covered for donor testing. In the case of an organ or tissue transplant, donor charges are considered Covered Expenses ONLY if the recipient is a covered person under this Plan. If the recipient is not a covered person, no ts are payable for donor charges.
- Podiatrists, i Covered Services (non-routine) from certified podiatrists acting within the scope of their license or certification. Routine foot care is covered for diabetics.
- Pre-admission tests performed prior to Hospital confinement
- Prescription drugs: The Prescription Drug Program is administered by Medco Health Solutions. Refer to the Prescription Drug section of this Plan.
- Preventive care (covered in-network only), including:
  - Annual gynecological examination and pap test
  - Periodic physical examinations, including TB skin test
  - Preventive mammograms (professional and facility charges) according to the following schedule:
    - Age 35-39: one baseline
    - Age 40+: one every year
  - Routine prostate screening (age 40+): one every plan year
  - Well-child care, including immunizations and vaccinations; see schedule in Covered Services Overview
- Radiation therapy: the treatment of cancer by X-rays or other sources of radioactivity which produce ionizing radiation
- Rehabilitative therapy: the treatment that leads to attainment of maximum medical improvement and function
- Skilled Nursing Facility care, including:
  - Room and Board and Other Services and Supplies. Covered Expenses for Room and Board will be the facility's regular daily charge for a semi-private room.
  - Prior Hospital confinement is not required if Medical Management authorizes the care.
  - If not authorized by Medical Management, care in the facility must begin within 14 days after leaving a Hospital, must be needed for the same cause as the hospitalization and must be supervised by a Physician. The Hospital confinement must have been for at least three days.

- Licensed Mental Health and Substance Abuse Provider Services of a Licensed Mental Health and Substance Abuse Provider for Mental Health or Substance Abuse treatment
- Medical supplies; some durable medical supplies such as hospital electric -powered wheelchairs, etc. may require prior authorization
- Blood or blood plasma; only if not donated or replaced
- Durable medical equipment (such as iron lung, rental of dialysis machines, resuscitators, hospital-type beds, traction equipment, wheelchairs and walkers); may require prior authorization
- One pair of eyeglasses or contact lenses required to replace human lenses lost due to cataract surgery
- Orthopedic braces; may require prior authorization
- Oxygen and charges for giving it, including rental of required equipment
- Rental of a device to help breathing when paralyzed
- Surgical supplies required during a surgical procedure
- Nursing services recommended and approved by a Physician, including:
  - Services of a trained nurse
  - Services of a licensed or certified Nurse Midwife or Nurse Practitioner acting within the scope of that license or certification
  - Covered Services given by a licensed or certified Nurse Midwife or Nurse Practitioner are payable on the same basis as Covered Services given by a Physician
- Nutrition Services; limited to those requiring medical management and skilled administration and maintenance
- Oral surgery charges related to accidental Injury (treatment must be completed within 12 months of the date of the accident) by external force to natural teeth, including necessary facility charges for dental oral surgery
- Orthognathic surgery
- Charges for the surgical treatment of Temporomandibular Joint Disorder (TMJ)
- Organ/Tissue Transplant: The BlueCross BlueShield Centers of Excellence Transplant Program selectively identifies Participants. These Centers of Excellence have experience with certain high-risk, high-cost, transplant-related medical and surgical procedures. Use of Centers of Excellence facilities is voluntary.

PROVISION	USING THE CENTERS OF EXCELLENCE (BlueCross BlueShield or other Network)	NON-NETWORK
Medical Expenses	80% $500 special Deductible applies if no prior authorization	60%
Hotel Accommodations For one companion* to accompany the patient (maximum $50 per day), up to maximum of 21 days per Plan Year	Lifetime max. $10,000 combined with meals and travel	Not covered
Meals and other necessary expenses for one companion*	Lifetime max. $10,000 combined with hotel and travel	Not covered
Travel To and from the site of the transplant, procedure, surgery, or necessary follow-up for the patient and companion* traveling on the same day(s) (limited to Coach Class)	Lifetime max. $10,000 combined with hotel and meals	Not covered
*In the case of a covered minor child Dependent who is in need of a covered transplant, the transportation of two companions will be covered.		

- Chiropractic care limited to spinal manipulation for musculoskeletal conditions. Not covered for maintenance therapy or other diagnoses. X-rays, office visits, supplies and physical therapy are not covered. Limit to 10 visits per year.
- Contraceptives (oral contraceptives and some contraceptive devices) are covered under the Prescription Drug Program. They include but are not limited to birth control pills and diaphragms. Other contraceptive devices, including IUD's and Depo-Provera, are covered under the Medical plan and subject to the appropriate Deductible and Coinsurance.
- Disposable diabetic supplies available through the pharmacy program include but are not limited to:
  - Test strips
  - Insulin pump tubing
  - Alcohol swabs
  - Lancet device
  - Syringes
  - Reservoirs
  - Glucometer
- Family planning services, including:
  - Infertility services to correct a Medical Condition only; not to aid in conception
  - Tubal ligation; reversals not covered
  - Vasectomy; reversals not covered
- Health Care Provider services from a licensed or certified Health Care Provider acting within the scope of that license or certification. Covered Services for allied and ancillary Health Care Providers are payable on the same basis (in and out-of-network) as Covered Services given by a Physician.
- Home health care services given by a Home Health Care Agency, including:
  - 200 visit maximum per Plan Year
  - Four hours of home health aide care counts as one visit. Each visit by other members of the home health care team counts as one visit.
  - Temporary or part-time nursing care by or supervised by a Registered Graduate Nurse (RN)
  - Temporary or part-time care by a home health aid
- Hospice care services at an inpatient Hospice facility or in the patient's home. The Physician must certify that the patient is terminally ill with six months or less to live. Services covered include:
  - Room and Board charged by the Hospice
  - Other Services and Supplies, including counseling
  - Part-time nursing care by or supervised by a Registered Graduate Nurse (RN)
  - Home health care services as shown under home health care; prior Hospital confinement is not required
  - Services for family members covered under Hospice Care include:
    - Counseling given by a licensed social worker or a licensed pastoral counselor
    - Bereavement counseling given by a licensed social worker or a licensed pastoral counselor within six months after the patient's death, for up to 15 visits
    - Counseling services given in connection with Hospice Care will not be considered as treatment for mental health
- Hospital services, including:
  - Room and Board
  - Charges for a ward, a semi-private room or an intensive care unit. The full amount of Reasonable and Customary Charges will be counted as Covered Expenses.
  - If admitted to a private room, charges up to the Hospital's regular daily charge for a semi-private room will be counted as Covered Expenses.
  - Hospital services are limited for mental health and substance abuse treatment. Refer to the Behavioral Health section.

Covered Services

The following Covered Services apply to the Medical Plan, including the Prescription Drug Program and the Behavioral Health Program.

Covered Services must comply with the following standards. The service or treatment must be:

- Medically Necessary;
- Clinically appropriate;
- Not considered Experimental or Investigational;
- Required for treatment; and
- Recommended and approved by the attending Physician, unless noted otherwise in the treatments and services listed on the following pages.

If you have questions about Covered Services and/or exclusions:

- For medical and behavioral health inquiries, call Empire Customer Service at (800) 675-1277.
- For prescription drug inquiries, call Medco Health Solutions Member Services at (800) 988-4105.

You and your Health Care Provider share responsibility for deciding which services and supplies are received. However, the Plan provides benefits only for Covered Services.

The recommendation and approval of a diagnostic or treatment alternative by the attending Physician does not mean the procedure is covered by the Plan.

The Plan covers the following services:

- Acupuncture treatment by a Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S), Doctor of Osteopathic Medicine (D.O.) and certified licensed acupuncturist
- Allergy testing and treatment for the diagnosis and treatment of allergies, including tests or treatment materials. Network Copayments apply to office visits for diagnostic testing, but not to office visits for injections only.
- Ambulatory Surgical Center services for covered surgical procedures at an Ambulatory Surgical Center
- Anesthetics and charges for giving them when administered in an outpatient or inpatient facility
- Behavioral Health Licensed Provider services for mental health or substance abuse treatment
- Behavioral Health Treatment:
  - Inpatient - Benefits for mental health and substance abuse treatment in a Hospital or Treatment Center will be limited to a total of 30 days per Plan Year. Benefits for treatment of substance abuse will be further limited to 60 days per lifetime.
  - Outpatient - Benefits for mental health and substance abuse treatment will be limited to 30 visits per Plan Year. When the Anthem Program is not followed, benefits will be reduced to the out-of-network benefit level.
  - Pharmacology - Office visits to review medication for a mental health condition are treated as "medical," so the office visit Copayment feature applies.
- Birthing Center services, including Other Services and Supplies, of a licensed Birthing Center related to labor and delivery at the Birthing Center
- Chemotherapy administered for the treatment of neoplastic, abnormal tissue formation with chemical agents. It can be administered orally, subcutaneously, intramuscularly, intravenously, intra-arterially, intrathecally (within the spinal canal) or by instillation into a body cavity, such as the thorax, abdomen or bladder.

Covered Services Continued

SERVICE	IN-NETWORK	OUT-OF-NETWORK
Ambulance	20%	20%
Emergency Room	$150 Copayment*, then 20%	$150 Copayment*, then 20%
Emergencies include: broken bones, head injury, knife or gunshot wound, or a severe burn; non-accidental, but critical life-threatening situations (e.g. heart attack, stroke, acute asthma attack, etc.); sudden onset of symptoms that suggest a serious or life-threatening situation, such as chest pains. If a Participant obtains medical care in an emergency room and her/his symptoms did not indicate an emergency, no benefits will be paid. If a Participant is admitted to the Hospital or if surgery is performed, Medical Management needs to be notified within one business day. **Copayment is waived if Participant is admitted into the Hospital and Medical Management is notified.*		
Urgent Care Center	20%	40%
Hospice Care[1]	20%	40%
Home Health Care[1] (200 visits/Plan Year)	20%	40%
Behavioral Health (30 days/Plan Year in- and out-of-network combined)		
Inpatient Mental Health[1]	20%	40%
Outpatient Mental Health[2]	20%	40%
Inpatient Substance Abuse (60 days/lifetime in- and out-of-network combined)	20% (subject to medical Deductible)	40% (subject to medical Deductible)
Outpatient Substance Abuse	20%	40%
Other Services		
Durable Medical Equipment[2]	20%	40%
Radiation Therapy	20%	40%
Prosthetic Devices[2]	20%	40%
Hemodialysis	20%	40%
Organ and Bone Marrow Transplants[1] (non-experimental and non-investigative)	20%	40%
Blood Plasma, Blood Derivatives and Blood Products	20%	40%
Physical/Speech/Occupational Therapy (10 visits per therapy each Plan Year; preauthorization required for additional visits)	20%	40%
Chiropractic Care (10 visits/Plan Year) Spinal manipulations are covered for the treatment of nerve interference. X-rays performed by a Chiropractor are excluded.	20%	40%
Vision Discount	Discounts for routine eye examinations, eyeglasses, contact lenses and laser vision correction are available through Davis Vision providers. Obtain program details on-line at www.davisvision.com (code 7253) or call (800) 999-5431.	

[1] *Prior authorization is required.*
[2] *Prior authorization may be required for specific services based on medical necessity. Contact Empire BlueCross BlueShield for verification.*

All coverage amounts stated as 80% or 60% are applied after the applicable in- or out-of-network Deductible is satisfied.

Claims and Appeals Review

Reviews and decisions for medical, behavioral health and prescription drug claims and appeals will be made within the allowable timeframe listed below and on the following page.

TYPE OF CLAIM	DECISION TIMEFRAME FOR REVIEW OF CLAIMS AND APPEALS
Pre-service Urgent Claims	The Plan will notify you within 72 hours of any denial. If additional information is needed, the Plan will notify you within 24 hours and allow you 48 hours to respond. The Plan will make a determination within 48 hours of the earlier of: receipt of the information or the end of the period you were given to provide information. The Plan will make a decision on any appeal within 72 hours.
Concurrent Claims	The Plan must notify you prior to the end of an authorized treatment if the benefit is reduced or terminated. If you request to extend a treatment beyond the prescribed course and it involves an urgent care claim, you must make the request at least 24 hours prior to the end of the prescribed treatment and the Plan will make a decision within 24 hours of receipt of your request. If you request to extend a treatment and it does not involve an urgent care claim, the Plan will make a decision within 15 days. You will have 180 days following receipt of a denial to request an appeal. The Plan will make a decision on any appeal within 15 days, or if it involves an urgent care claim, within 72 hours. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 15 days.
Pre-service Regular Claims	The Plan must notify you within 15 days of any denial, or send written notice for a 15-day extension. If an extension is needed due to lack of information from you, you will have 45 days from receipt of the notice to provide the information. You will have 180 days following receipt of a denial to request an appeal. The Plan must make a decision on any appeal within 15 days. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 15 days.
Post-service Claims	The Plan must notify you within 30 days of any denial, or send written notice for a 15-day extension. If the extension is needed due to lack of information from you, you will have 45 days from receipt of the notice to provide the information. You will have 180 days following receipt of a denial to request an appeal. The Plan must make a decision on any appeal within 30 days. You will have 60 days following receipt of a denial to request a second appeal. The Plan must make a decision on the second appeal within 30 days.

Coordination of Benefits

Empire coordinates benefits with other health plans in which you or your Dependents may participate. Other plans include:

- Another employer group health plan
- A plan resulting from the No-fault Automobile Insurance Law
- A government or tax-supported program, excluding Medicaid

Benefits from this Plan will be determined so that when they are combined with benefits from any other plans; they will not exceed that which would have been paid under this Plan if no other coverage existed.

- If this Plan is primary, it will pay benefits first. Benefits under this Plan will not be reduced due to benefits payable under other plans.